STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General Provisions

A. Purpose and Upper Limit of Payment

This plan establishes the methods and standards for reimbursement of outpatient hospital services. The plan sets a prospective rate of payment which will not exceed the upper limit of payment for comparable services furnished under comparable circumstances under Medicare as required by 42 CFR 447.321.

Effective October 1, 1999, the Outpatient Fee Schedule rates increased. The new rates can be found in the Hospital Manual. In addition, a portion of the small hospital access payment (see 4.19-A Section VI) will be allocated to outpatient services.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

- To contain growth in the rate paid for outpatient services.
- To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.
- To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.

C. Definitions

The following definitions shall apply for the purpose of reimbursement under this plan.

1. Outpatient - A patient who is receiving professional services at a hospital which does not admit him and which does not provide him room and board and professional services on a continuous 24 hour basis.

2. Outpatient services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician to an outpatient by an institution licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an

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3. Surgical service - Surgical services are defined as the operative procedures set forth in the ICD-9-CM surgical procedure codes. Emergency and nonemergency surgical services are included as surgical services.

4. Non surgical services - Emergency or non-emergency services rendered by a physician which do not meet the criteria for surgical or treatment/theraphy/testing services.

   a. Emergency service - Services rendered to clients who require immediate medical intervention for any condition for which delay in treatment may result in death or serious impairment.

   b. Nonemergency service - Nonemergency services are defined as scheduled or unscheduled visits to an outpatient hospital clinic or emergency room where a professional service is rendered.

5. Treatment/Therapy/Testing service - Such services are defined as laboratory, radiology, dialysis, physical, speech, occupational, psychiatric, and respiratory therapies and testing services.

II. Scope Of Services

Effective with dates of service July 1, 1988, hospitals certified for participation under the Health Insurance for the Aged Program under Title XVIII of the Social Security Act and participating under the Medicaid Program shall be reimbursed for outpatient services rendered to eligible clients according to one of three types of outpatient services categories. These categories are prioritized as follows:

Surgical services

Nonsurgical services

Treatment/Therapy/Testing services

A. Surgical Services

1. Services Included in Surgery Payment

Surgical services shall include those outpatient services for which a valid ICD-9-CM surgical procedure code is indicated. For the purposes of reimbursement, surgical services shall be

all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, operating room, recovery room, prosthesis, etc. Physician's services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM surgical procedures shall be classified by procedures of similar complexity which consume a like amount of resources. An all-inclusive fee shall be established for each class.

b. Fees for surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function. A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of the Commission.

c. In the case of multiple surgeries only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

B. Nonsurgical Services

1. Services Included in Nonsurgical Services Payment

Nonsurgical services shall include those scheduled and unscheduled emergency or clinic visits to hospitals which do not meet the criteria for surgical services, but which involve a professional service or direct patient contact other than that associated with a treatment/therapy/testing service. For purposes of reimbursement, nonsurgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, emergency room, clinic, etc.

Physician services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Nonsurgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM disease classifications shall be grouped by procedures of similar complexity which consume a like amount of resources. An all inclusive fee shall be established for each class.

b. Fees for nonsurgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM diagnostic procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function.

A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of the Commission.

c. In the case of multiple diagnosis only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

C. Treatment/Therapy/Testing Services

The methods and standards for payment of treatment/testing/therapy services are divided into two categories:

. Laboratory and Radiology

. Other Treatment, Therapy and Testing Services

1. Laboratory and Radiology

a. Services Included in Payment Amount

Payments for laboratory and radiology services rendered to outpatients shall consist of a fee for services. The fee excludes payment for services rendered directly to a patient by a physician (professional). If laboratory and radiology services are combined with surgical or nonsurgical services, no separate payment shall be made.

b. Payment Method

i. Payments for technical radiology and laboratory services shall be made based on the lesser of the charge or fixed fee for each CPT coded procedure.

ii. The fee for technical radiology or laboratory services is based on a percentage of the amount for a total procedure on the fee schedule for independent radiology or laboratory services.

2. Other Treatment, Therapy and Testing Services

a. Services Included In Payment Amount

Treatment, therapy, and testing services under this part include dialysis treatment, respiratory, physical, speech, occupational, audiological therapies, psychiatric treatment, and testing. The payment for each treatment and testing category is a payment per service. Therapy services rendered under this part include the professional service component. If such services are provided in conjunction with surgical or nonsurgical services, no separate payment shall be made.

b. Payment Method

Services under this part shall be reimbursed the lesser of the charge for the service or the fixed fee. A fixed fee is assigned for each service type under this part.

III. Utilization Review

1. The Commission shall review the medical necessity of all services rendered under this part. Such review may occur on a pre-or post-payment basis or, at the option of the Commission, may occur prior to the rendering of the service. Where such services are determined not medically necessary, payment shall be recovered using the most expedient means, or denied in its entirety.

2. The Commission shall also review the appropriateness of billing for all service types. Such review may occur pre- or post-payment and may produce payment denial or recovery by the most expedient means possible.

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IV. Payments to Out-of-State Providers

Payments to out-of-state providers shall be made based on the lesser of the fixed fee specified for the service or the charge for the service in the case of surgery, nonsurgery or treatment, therapy and testing services.

2b. Rural Health Care

Reimbursement for medically necessary services will be made at 95% of the all-inclusive patient encounter fixed rate, per visit, as established by the Medicare Regional Intermediary. A copy of the actual costs and utilization reports shall be submitted to this agency at the end of each fiscal reporting period to enable us to determine the reimbursement due for the fiscal period.

Services rendered to individuals age sixty-five (65) or older, and disabled, who are eligible for benefits through the Medicare program, will follow the Medicare billing procedures established by the Regional intermediary. Coinsurance and Deductibles will be paid by the Medicaid (Title XIX) program where the individual has joint eligibility under both programs.

2c. Federally Qualified Health Centers

The South Carolina Department of Health and Human Services (DHHS) will accept the Modified Medicare Cost Report for Rural Health Clinics as the cost report format for the Federally Qualified Health Centers in South Carolina. The reports, as submitted, shall be reviewed for accuracy, reasonableness, and the allowability of costs as defined by Medicare reasonable cost principles. Reimbursement will be made at 95% of Medicare reasonable costs with the following constraints: (1) The minimum productivity level shall be for the provision of services from 22 to 27 patients per day; (2) Overhead costs shall be limited to not more than thirty percent (30%); and, (3) Out-of-state Federally Qualified Health Centers shall be paid the statewide average encounter rate as determined from the most recently completed state fiscal year. To ensure that reimbursement will be made at 95% of Medicare reasonable costs, subject to the above mentioned constraints, adjustments to cost shall be made on a retrospective basis based upon our review of the provider's FYE cost report. Furthermore, the reported information shall be utilized for establishing or modifying the rates of payment for future services rendered by the Federally Qualified Health Center. For those facilities that are not PHS grantees but are designated as "look alikes," the same cost principles and constraints shall apply as mentioned above for the Federally Qualified Health Centers.

2e. Indian Health Service (IHS) Facilities:

Effective July 1, 1999, DHHS will reimburse IHS facilities (638 facilities) at the rate as determined by the Indian Health Service. For Calendar year 1999, the rate is published in the Federal Register/Vol.64, No. 16/Tuesday, January 26, 1999/Notices, page 3955. Subsequent year rates shall be announced in the Federal Register. The rate shall be an all-inclusive encounter rate per visit for the provision of medically necessary out-patient services provided to both Native and non-Native Americans.

Coinsurance and Deductibles will be paid by the Medicaid Program (Title XIX) program where the individual has joint eligibility for Medicare and Medicaid.

both programs; however, The Medicare (Title XVII) program is primarily responsible for reimbursement in these cases. Non-Medicare benefits will follow the South Carolina Medicaid State Plan as described in 42 CFR 337.371 (c) (2).

3. Other Laboratory and X-Ray Services:

Reimbursement is calculated as it is for physicians. Refer to 5.

4.b Early and Periodic Screening, Diagnosis and Treatment Screening Services:

For providers other than individual practitioners a negotiated encounter rate not to exceed reasonable cost. This rate shall also serve as the upper limit for reimbursement for individuals practitioners providing the same services.

Comprehensive Health and Developmental History including
Assessment of both Physical and Mental Health Development

Assessment of Nutritional Status	Vision Screening
Comprehensive Unclothed Physical Examination	Hearing Screening
Ear, Nose, Mouth and Throat Inspection	Blood Pressure
Developmental Assessment	Anemia Screening
Assessment of Immunization Status and Administration	Health Education

Optional services as deemed medically necessary by the provider:

Lead Screening	Tuberculin Skin Test	Urinalysis
Sickle Cell Test	Parasite Test	

Immunizations:

Vaccines for Medicaid eligible children are obtained through the State Health Agency as provided under the Vaccines for Children Program. An administration fee will be reimbursed to Medicaid providers who administer immunizations in conjunction with an EPSDT screening or other billable service, as well as, for "shots only" visits.

Payments for EPSDT Services that are not otherwise covered:

Services not listed as covered services in the state agency manuals/state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. The reimbursement rate for these services will be 80% of statewide usual and customary fees. If the provider is a government agency and/or a non-profit organization, the reimbursement will be no greater than actual costs. This in compliance with 45 CFR Subpart Q.

Private Duty Nursing Services:

This reimbursement may not exceed that which the agency would reimburse for institutional care as specified in Section VI; G Payment for Administrative Days. These services are reimbursed at an hourly rate which does not exceed usual and customary charges. Payment per week cannot exceed the payment for a week of institutional care. An institutional setting is the alternative placement for 24 hour continuous care.

Personal Care (Aides) Services:

Personal Care (Aides) Service will be reimbursed through a fee for service methodology based on the delivery of units of service. A unit of service will be one (1) hour. Payments to state agency providers will not exceed the cost of rendering the service. Reimbursement for these services does not exceed usual and customary charges for the same service in the surrounding locality.

Physician Therapy, Occupational Therapy and Psychological Services:

These services include physical therapy services, occupational therapy services and psychological testing, evaluation and counseling services and are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

Nursing Services for Children Under 21:

Initial reimbursement to providers of nursing services for children under the age of 21 is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable services under comparable circumstances. Reimbursement will be provided on a unit of a quarter of an hour basis for skilled nursing services and a per encounter basis for medication administration and other similar procedures. The current reimbursement rates are based on rates or fees reimbursed for similar services.

State and local government providers must submit annual actual cost and service delivery data. The State shall utilize Medicare reasonable cost principles as well as OMB Circular A-87 and other OMB circulars as may be appropriate during its review of actual allowable costs. Future reimbursement rates to state and local government providers shall be the lesser of actual allowable documented cost or the established fee.

4.c Family Planning Services and Supplies:

Family Planning Services are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

5. Reimbursement for physicians, osteopaths, and podiatrists will be the amount calculated by using a State agency determined percentage of the Medicare Resource Based Relative Value System (RBRVS) Fee Schedule, or the amount calculated by using a payment schedule based upon the relative value of each procedure code multiplied by a conversion factor assigned by the State Agency, or lesser of actual charge. Relative values are based on those established for the Medicare RBRVS. For those procedures not having a relative value, reimbursement is based on data collected within the Medicaid Management Information System or by a review conducted by medical personnel to establish the relative value. The percentage and/or the conversion factor will be reviewed annually prior to the close of each State fiscal year. Updates to the payment schedule may be targeted to specific procedure codes or ranges of procedure codes. Some of the considerations for targeting updates are: ensuring provider participation, eliminating inequities with the system, ensuring providers recover out-of-pocket expenses, etc. The payment schedule is applied uniformly to all reimbursement without consideration to locality or specialty of the physician.

Alternate Reimbursement Methodology (ARM)
A provider of physician's primary care services may opt to be reimbursed under the Alternate Reimbursement Methodology (ARM).

The ARM rate is based on the historical reimbursement and utilization data for the core set of primary care services including a payment for management of a recipient's health care services. The rates are set for appropriate age and sex groupings and categories of eligibility. The monthly ARM rate, for the core set of primary care services, will be reimbursed to a Medicaid provider based on the number of Medicaid recipients enrolled in the provider's practice.

The ARM rate will not exceed the upper payment limits as specified by 42 CFR 447.361. The ARM rate will not exceed the amount that can reasonably be estimated would have been paid for those same services on a fee-for-service basis to a non enrolled population group.

The ARM rate will be reviewed annually to assure reasonableness and adequacy as compared to those same services on a fee for service basis.

A **Primary Care Access Incentive Payment** to actively enrolled primary care physicians who have served a large volume of Medicaid recipients will be developed based on the volume of unduplicated recipients served by any given physician during the first three quarters of the state's fiscal year. The primary care services which the SCDHHS will use in order to determine the number of unduplicated Medicaid recipients will consist of office visits, prenatal and postpartum visits, and Early and Periodic Screening, Diagnosis and Treatment exams. The purpose of these payments will be to ensure and increase access of primary care services to Medicaid recipients. The **Primary Care Access Incentive Payment** (when added to prior payments for services rendered during the specified period) will not exceed the charges made by providers for office visits, prenatal and postpartum visits, and Early and Periodic Screening, Diagnosis and Treatment exams. The **Primary Care Access Incentive Payment** may vary from year to year when added to paid claims, but will not exceed 100% of charges. The primary care physicians targeted for these payments include the following: family physicians, general practitioners, gynecologists, internists, obstetricians, osteopaths, and pediatricians. Physicians currently practicing at a Federally Qualified Health Center or Rural Health Clinic have been excluded from these incentive payments.

For each recipient served, the primary care physicians will receive a **Primary Care Access Incentive Payment** based on the following schedule:

Payment per Recipient	Number of Recipients Served
$3.00	75 - 374
5.00	375 - 749
7.00	750 - 1,124
8.00	1,125 or more

In order to reimburse the Primary Care Access Incentive Payment, the SCDHHS will establish a pool of funds and may pay from $0 up to $1,000,000 in any given state fiscal year.

Reimbursement for laboratory (pathology) services performed by individual practitioners is calculated as specified in 5.

End State Renal Disease - Reimbursement for ESRD treatments, either home or in center, will be an all inclusive fee based on the statewide average of the composite rates established by Medicare. The reimbursement will be an all inclusive fee to include the purchase or rental, installation and maintenance of all equipment.

6.a Podiatrists' Services:

Reimbursement is calculated in the same manner as for Physicians' services. Refer to 5.

6.b Optometrists' Services (Vision Care Services):

Payment will be according to an established fee schedule for all services not provided through the sole source contract. Effective February 1, 1982.

6.c Chiropractor's Services:

Payment will be according to an established fee schedule.

6.d Certified Registered Nurse Anesthetist: Reimbursement is calculated at one-half the rate of the Anesthesiologist, Physician Services. Refer to 5.

Nurse Practitioner: Reimbursement is calculated at 80 percent of the rate for Physician Services. Refer to 5.

Psychologists: Psychological services are reimbursed at an established tatewide fee schedule as based on the Methodology outlined in the Physician Section 5, Attachment 4.19-B, Page 2a. All requirements identified under CFR 447.200ff and 447.300ff shall be met.

Licensed Midwives' Services: Reimbursement is calculated at 65% of the rate for physician services. Refer to 5a and 5b.

7. Home Health Services:

A. Nursing Services, Home Health Aide Services, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology are provided and reimbursed based on the lesser of allowable Medicare costs, charges, or the Medicare cost limits. Medical supplies which are used in the provision of routine home health services are initially reimbursed based on charges; however, during the fiscal year end cost settlement, an adjustment is made reflective of the cost to charges ratio for medical supplies. Durable medical equipment purchased through a home health agency will be reimbursed in accordance with Section 12 (c) of this plan 4.19-B. Home Health Agencies entering the Medicaid program for the first time will be